PERMISSION TO USE AND SHARE PROTECTED HEALTH INFORMATION (PHI)

MEMBER INFORMATION:

Member Name				Date of Birth	
UHA ID Number				Phone Number	
Member Address					
City		State		Zip	
Email					

PEOPLE/GROUP MEMBER ALLOWS TO RECEIVE PROTECTED HEALTH INFORMATION (PHI):

Name or Group				Date of Birth, *if applicable*:	
Phone				Relationship	
Member Address					
City		State		Zip	
Email					
Authorization to change information as needed (circle one): Yes | No					
Describe each purpose to share PHI, or indicate that sharing PHI is at the request of the member: _____ At the request of the individual (initial in the space provided); or					

TYPE OF INFORMATION ALLOWED TO BE RECEIVED:

By initialing the spaces below, I give permission to use and/or share the following:

___ Entire medical record (except the Specially Protected Information).

Partial record, including (check all that apply):

___Clinicians office chart notes
___Transcribed hospital reports
___Progress notes
___Medical records needed for continuity of care
___Most recent five (5) year history
___Diagnostic imaging reports
___Demographic sheet/face sheet
___ Adverse Benefit Determination notices
___Other:

___Dental records
___Laboratory reports
___Pathology reports
___Emergency and urgent care records
___Billing statements
___Photographs and Videotapes
___Enrollment records
___Grievance and/or appeals records
___Hearing documentation

Specially Protected Information: Except as specifically permitted by law, the following types of information will not be shared unless I authorize the disclosure by placing my initials in the space(s) next to type of information to be disclosed:

___HIV-positive test results and HIV diagnosis*
___Mental health information and/or records*
___Genetic testing information and/or records*
___Drug/alcohol diagnosis, treatment or referral information**

* Must be initialed to be included in other documents. Records will not be released without your initials specifying that you have granted this specific release authority.

** PROHIBITED RE-DISCLOSURE: this information has been shared with you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

MEMBER RIGHTS:

I understand:

- I have the right not to sign this form. If I do not sign this form, it will not affect my health plan eligibility or benefit coverage with UHA.
- I have the right to cancel this permission in writing at any time. If I cancel this permission, the information listed above will no longer be used.
- Any uses of information already given with my permission cannot be taken back.

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☐ I allow Umpqua Health Alliance as my health plan and its partners to share PHI approved in this form to the people/group identified on this form.

☐ I allow Umpqua Health Alliance to communicate with myself, my personal representative and persons listed on this form via mail as well as secure email (upon consent) when requested.

☐ I understand that information shared based on this permission might be shared again and might not be protected under federal and state law anymore. I understand that federal and state law may limit sharing of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral.

☐ I accept that I have read this form and understand it.

Signature		Date
Print Name		

Unless I cancel this permission, this form will be good for ONE YEAR (12 Months) from the date of my signature or until this earlier date: _____/_____/_____.	
If I am not the Member, I am:	☐ Parent*** ☐ Grandparent ☐ Legal Guardian (attach copy)*** ☐ General/Durable/Health Care Power of Attorney (attach copy) *** ☐ Executor or administrator of the estate (attach copy) ☐ Next of kin or other family member (if relevant law provides authority)

***PLEASE NOTE:

- Please attach legal documentation if you are:
  - The court appointed legal guardian;
  - Durable power of attorney for health care;
  - General power of attorney or durable power of attorney that includes the power to make health care decisions;
  - Health care proxy for the member;

  If possible, please include a photocopy of a valid driver's license or official ID for the person(s) you listed on the form.
- If you are a parent with a court order custodial agreement or parenting plan that outlines health care decision making for the child(ren), a copy must be attached with this form.
  - If the custodial parent wants to withhold medical information from the other parent, they will need to provide proof of parental rights termination. If parental rights are terminated, the noncustodial parent can no longer access the child(ren)'s medical information.
- Children of the following ages MUST sign this form to release their PHI to any person or facility:
  - An emancipated minor
  - 14 years of age & above - Chemical Dependency
  - 15 years of age & above - All other medical conditions

SUBMIT THIS FORM TO UHA CUSTOMER CARE BY ONE OF THE FOLLOWING OPTIONS:

- **Fax:** 541-677-6038
- **Email:** UHCustomerCare@umpquahealth.com
- **Mail:** Umpqua Health Alliance
  Attn: Customer Care
  3031 NE Stephens St.
  Roseburg, OR 97471

Get this information in any language or format for free. All interpretation services are free. Call 541-229-4842 (TTY 711).

Obtenga esta información de forma gratuita en cualquier idioma o formato. Todos los servicios de interpretación son gratuitos. Llame al 541-229-4842 (TTY 711).